Directions: Please fill in all blanks, print and sign the form, submit to Family Medicaid by fax at **208-528-5980**. Maintain original in participant's records**.** You may choose to submit the form electronically to: familymedicaid@idhw.state.id.us

EPSDT Service Coordination
Enhanced Plan Participation

IDENTIFYING INFORMATION

Name of Participant: _____ Medicaid ID#: _____

Name of Agency and Agency Provider#: _____

CERTIFICATION

I have assessed _____ on _____ and certify that this
(Name of participant) (date)

participant meets the requirements in IDAPA 16.03.10 for receiving the above indicated service in the Medicaid Enhanced Plan.

_____ _____
Signature of DHW Employee Certifying Participant's Eligibility **Date**